CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program

Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
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www.healthoregon.org/dpp

AGENDA

"Oregon Tribes Dental Health Aide Therapist Pilot Project"
Annual Dental Pilot Project Program
Advisory Committee Meeting DPP #100
June 18, 2018 9:00am-4:00pm
Conference Call In: 1-888-273-3658 Code: 76 64 09

Location: Portland State Office Building		
9:00-9:10	Official Introductions, Agenda Review, Housekeeping	Bruce Austin, DMD Sarah Kowalski, RDH, MS
9:10-10:40	Trauma Informed Care Presentation/Training	Monica Manewal, CSWA CADCII Cassandra Sturtz, LPC CADCII
10:40-10:50	Break	
10:50-11:00	Introduction – Dr. Gita Yitta, NPAIHB Dental Project Manager	Gita Yitta, DDS
11:00-11:30	Mekinak Consulting Presentation	Joan LaFrance, Ed.D
11:30-11:45	*Questions and Answers*	Advisory Committee
11:45-12:15	Northwest Portland Area Indian Health Board, Update and Presentation; Update on CODA Application Process	Lynn Van Pelt, DDS Christina Peters
12:15-12:30	*Questions and Answers*	Advisory Committee
12:30-1:00	Preceptorship Process Presentation	Dane Lenaker, DDS, MPH
1:00-1:15	*Questions and Answers*	Advisory Committee
1:15-1:25	Public Comment Period	Public comments are limited to 2 minutes per individual
1:15-1:45	Lunch	
1:45-2:00	OHA Program Updates, Meeting Schedule, Site Visit Schedule	Sarah Kowalski, RDH, MS Kelly Hansen
2:00-2:45	Breakout Session; Small Groups for Discussions	OHA Program Staff Advisory Committee
2:45-3:20	Review Group Recommendations	OHA Program Staff Advisory Committee
3:20-3:30	Follow Up Items, Survey Information	Sarah Kowalski, RDH, MS Kelly Hansen
3:30-3:40	Public Comment Period	Public comments are limited to 2 minutes per individual

- Representatives from the Northwest Portland Area Indian Health Board are invited to participate fulling in the morning session of the Advisory Committee meeting; Afternoon session will include only members of the Advisory Committee as active participants in the meeting.
- Next Meeting: **Monday, September 10, 2018** – Portland State Office Building – 10:00am-12:00pm

Dental Pilot Project Advisory Committee meetings are subject to Oregon Public Meeting Law 192.610

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Quarterly Dental Pilot Project Meeting: DPP 100 Meeting Minutes

Date: Monday, June 18, 2018
Time: 9:00 AM – 4:00 PM
Location: OHA Public Health Division
800 NE Oregon Street
Portland, OR 97232
Conference Room 1A – First Floor

Committee Members Present:
Leon Asseal, Len Barozzini, Jennifer Clemens, Linda Mann, Connor McNulty, Carolyn Muckerheide, Karen Shimada, Kelli Swanson Jaecks

Committee Members Present Phone:
Paula Hendrix, Kelli Swanson Jaecks, Kyle Johnstone

Committee Members Absent:
Richie Kohli, Brandon Schwindt, Kenneth Wright

OHA Staff:
Bruce Austin, Danna Drum, Kelly Hansen, Sarah Kowalski, Jonathan Modie, Amy Umphlett, Cate Wilcox

Public Attendees:
Azma Ahmed, Sharon Hagan, Pam Johnson, Christina Peters, Jennifer Lewis-Goff, Allyson Lecatsas, Senator Laurie Monnes Anderson, Gita Yitta

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Meeting began at 9:08am. Committee Members and OHA Staff introduced themselves.

Agenda Item: Trauma Informed Care Presentation/Training: Presentation by Monica Manewal, CSWA CADCII and Cassandra Sturtz, LPC CADCII

Presentation and Discussion: Trauma-Informed Care, Definitions, Trauma and neuroscience, ACES study, Healthcare implications, Trauma informed care intention and application, Trauma informed examples, group exercise and resources. Guiding principles in trauma informed care: Safety, Trustworthiness & Transparency, Peer Support, Collaboration & Mutuality, Empowerment, Voice and Choice and Cultural, Historical and Gender Issues. Applicable to dentistry. Review of ACES and implications for dental providers.

- Definitions of Trauma, ACE, PTSD, Trauma triggers/reactions/symptoms

- Why trauma informed care? It impacts the entire person, occurs through the life span, affects vulnerable populations, affects how people arrive to and experience services, trauma has a direct impact on dental health
- Trauma and brain development, trauma and the brain, flipping the lid- people with trauma are operating from their amygdala- the alarm center, acting on instinct.
- Discussion around how it shows up in various practices.
- Approach all clients and whole practice as if you're treating someone with trauma, because it's more common than you might think and won't harm those who may not have trauma.
- Trauma brain- more sensitive to sensory information, hypervigilance - Divided attention creates safety; sustained attention is worse, brain acts first, thinks later, What we focus on gets stronger- pathways can change, grow, reconnect
- ACES- Adverse Childhood Experiences Study
- 1995-1997 Kaiser and CDC study, largest studies linking childhood abuse to health outcomes later in life
- CDC continues surveillance of ACES using updates on morbidity and mortality
- 17,000 people in study
- Primer video shows on ACES
- 6 guiding principles for TIC – safety, trustworthiness/transparency, peer support, collaboration/mutuality, empowerment/voice/choice, cultural/historical/gender issues
- Examples of practicing with TIC- provide explanations, changed language, realizing patients' coping mechanisms work for them, approaching all patients with understanding that many experience trauma, seek out alternative explanations for challenging behaviors
- Shifting question from 'what's wrong with you?' to 'what happened to you?' Look at outside factors that could have affected the person
- Group exercises on how to respond with trauma-informed practices and without

Agenda Item: Introduction – Dr. Gita Yitta, NPAIHB Dental Project Manager

Discussion: In compliance with the stipulated agreement, Dr. Gita Yitta has been contracted by the Northwest Portland Area Indian Health Board to fulfill the requirement that the project has a dental director.

Agenda Item: Mekinak Consulting Presentation

Discussion: Presentation. Review of the data captured. Review Indian Health Services level of classification of care. Review evaluation methodology.

Northwest Portland Area Indian Health Board, Update and Presentation; Update on CODA Application Process

Discussion: Dr. Lynn VanPelt reviewed the application to CODA for the Dental Health Aide Therapists (ADTEP's) Illasgvik College program. Review of CODA application, self-study document has been completed, the document is over 2000 pages. CODA accepted application and provided recommendation and where the program should make modifications to their application. Once the application is resubmitted, they have 6-12 months to schedule a site visit with the program. Program has completed a mock CODA site-visit. Two different previous dental school deans participated in the mock-CODA site visit to provide feedback to the program. Small issues in the application required further redaction of sensitive patient information.

Questions from the committee concerned what the anticipated resubmission date of the application to CODA.

Additional questions from the committee included clarification around subgingival scaling and root planning and periodontal procedures. DHATs are not taught this procedure. They are taught preventative, motivational interviewing techniques. CODA does not require SRP procedures. A DHAT is taught to treat uncomplicated gingivitis. There are 10 courses that address preventative courses and removal of subgingival calculus however they do not learn SRP procedures. They are taught when to refer. Students are actively taught how to do a complete prophylaxis.

Agenda Item: Preceptorship Process Presentation

Discussion: Dr. Lane Lenaker presented on the preceptorship process in the ADTEP program. Reviewed the preceptorship process, reviewed purpose of the preceptorship. 400 hours under direct supervision on their supervising dentist. Verified that the supervising dentist is teaching and guiding the student. They student must demonstrate competency in each area before being allowed to have their practice plan signed off on. Review preceptorship documentation process. This process allows the dentist to see the strengths and weaknesses of a student. Each procedure is rated in the Oregon pilot project as acceptable of unacceptable.

Morning portion of the meeting adjourned at 1:08pm

Public Comments: No Public Comments

Afternoon workgroup meeting.

Committee Members Present:
Leon Asseal, Len Barozzini, Jennifer Clemens

Committee Members Absent:
Paula Hendrix, Kelli Swanson Jaecks, Kyle Johnstone, Richie Kohli, Linda Mann, Connor McNulty, Carolyn Muckerheide, Karen Shimada, Brandon Schwindt, Kenneth Wright

OHA Staff:
Bruce Austin, Kelly Hansen, Sarah Kowalski,

Public Attendees:
Sharon Hagan, Allyson Lecatsas

Afternoon.

Meeting reconvend and began at 1:49pm.

Minutes: OHA program staff reviewed the responsibilities of the Oregon Health Authority (OHA). OHA is tasked with reviewing and evaluating the workforce model being tested in each approved dental pilot project and providing a closing report at the conclusion of the pilot project.

OHA is seeking input from the Advisory Committee on the topic areas that should be included in the final report. Small group discussions were held. Advisory committee members were asked to identify main topic areas that should be included, as well potential subjects to cover under each topic area.

Members identified broad categories, i.e training, education, licensing, scope of practice and supervision requirements.

Under each broad category, sub-categories for discussion were identified:

- **Education** – Training, CODA, Admission Requirements – RDH or DHAT model, both?, Competency Examinations, Board operated written exam, National Board Exam, WREB
- **Populations** – Public Health, Dental HPSA, Percentage of Population served, locations, Requirements to practice in underserved areas, Low-Income, Uninsured, Underserved, What other EPDH settings are allowed?
- **Scope of Practice** – Preventative, Restorative, Limitations – Out of Scope off the table items, papoose, behavioral management, etc., nitrous, etc.
- **Supervision** – Collaborative Agreement, Standing Orders, Could a Dental Therapist supervise others
- **Licensure and Regulatory** Requirements

Committee members present elected to begin conversations at future meetings around scope of practice.

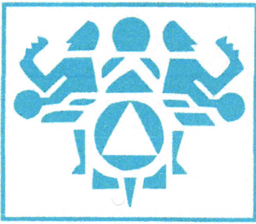
OHA clarified that there are pieces of this project that are not complete and we may have to revisit some areas as the project moves forward and we continue to evaluate the project, review charts, etc.

Next steps: - OHA will research topics ahead of the meetings; provide materials in advance for the committee to review ahead of the quarterly meetings; compare other states/countries; literature reviews, etc.

- Ultimately OHA will make recommendations
  - There will be areas that the group is unable to reach a consensus,
  - At our next meeting, we will lay out the rules for what we will include as recommendations in the final report and what process we will use to determine that in the circumstances where we do not have a consensus among the group

Afternoon portion of the meeting adjourned

Public Comments: No Public Comments



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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www.npaihb.org

May 17, 2018

Dear Dr. Austin,

I am happy to announce as of May 1, 2018 we have contracted with Dr. Gita Yitta, DMD to be providing initial support to the project. You have had the pleasure of working with her on the advisory committee, and besides being familiar with the project, she has extensive experience in dentistry, dental education and administration.

Dr. Yitta received her Bachelor's Degree in Economics from Carnegie Mellon University. During the economic downturn, she left her position as a healthcare analyst for Bear Stearns to attend dental school at the University of Pennsylvania - School of Dental Medicine. She then completed her general practice dentistry residency at St. Barnabas Hospital in Bronx, NY. In addition, Gita holds a Professional Certification in Healthcare Administration from the University of Vermont.

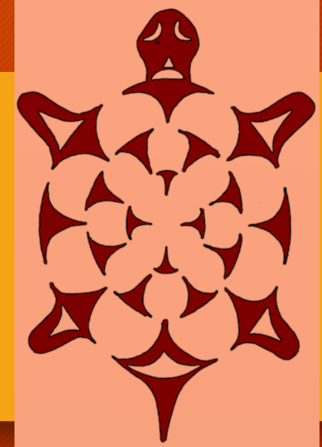
Currently, she is the Dental Program Coordinator for Klamath Community College's Dental Assisting Program and is the Associate Medical Director of Oral Health for AllCare CCO. She resides in Central Point, Oregon and continues to treat patients part-time in both Medford and Grants Pass.

I have attached her resume and the scope of work for the pilot project.

Thank you

Christina Peters
Native Dental Therapy Initiative Project Director
Northwest Portland Area Indian Health Board

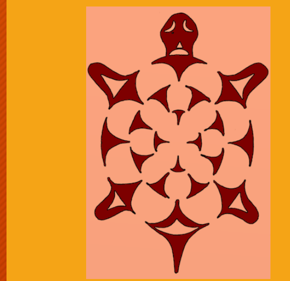
Oregon Pilot Study



Mekinak Consulting – Seattle, Washington

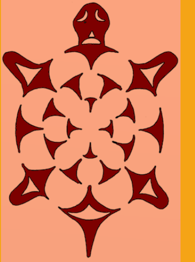
Northwest Portland Area Indian Health Board

CTCLUSI



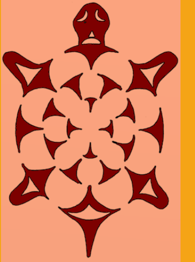
- Located in SW Oregon, the CTCLUSI is a self-governing tribe through the federal Indian Self Determination and Education Assistance Act.
- The Tribe contracts with the Indian Health Service (IHS) and negotiates annual funding agreements under the provisions of the Act.
- Tribal clinics do not operate for profit – they are stewards of dental care for their people
- The clinic operates on a “demand for care” bases

Funding - CTCLUSI



- Medicaid (OHP) and private insurance are billed for care
- NA patients (members of any recognized tribe) not covered by Medicaid/private insurance are covered by the tribe's IHS funding
- As "demand for care" clinic, more care can be provided through less expensive providers such as a DHAT

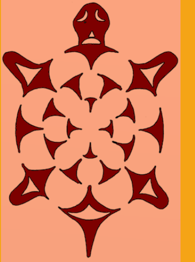
NARA



- The Native American Rehabilitation Association (NARA) offered dental services on Jan. 11, 2016 and opened a permanent clinic on May 23, 2016
- The clinic is located in SE Portland
- NARA bills Medicaid, HRSA funds and private insurance to cover patient costs
- The clinic also applies for grant funds
- The patient base is primarily NA; however, the clinic serves anyone who wants care

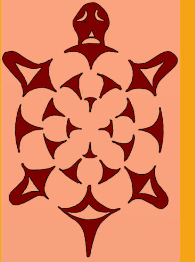
Native American Rehabilitation Association of the Northwest, Inc.

Both Clinics Use IHS Level of Care Classifcations



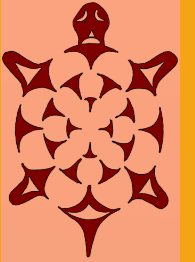
- IHS's principle: use the available resources to provide the greatest benefit to the greatest number of people for the longest time possible
- Services that alleviate pain or prevent disease are given a higher priority than those intended to prevent or contain disease, or correct damage caused by disease
- There are 6 Levels of Care
- IHS recommends providing services that fall within the first 3 levels,
- This is basic care – IHS believes it is most cost-effective and allows for services to more people in a community.

IHS Level of Care Classifications



- Level 1: Emergency Oral Health Services
- Level 2: Preventive Oral Health Services
- Level 3: Basic Oral Health Services
- Level 4: Basic Rehabilitation Oral Health Services
- Level 5: Complex Rehabilitation Oral Health Services
- Level 9: Exclusions

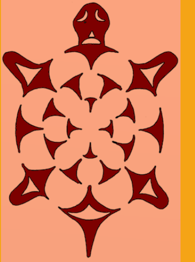
The Oregon DHAT Pilot Study Evaluation Questions



How has addition of a DHAT influenced:

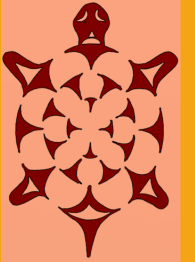
- Access to dental services
- Educational outreach to tribal and urban NA communities
- Production of high quality of services
- Costs of services
- Patient satisfaction with services

Evaluation Assumptions



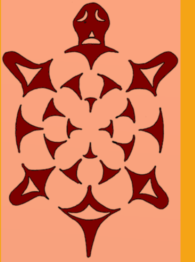
- Access increases as DHAT's provide basic care
- DHAT's provide high quality and safe services
- Dentists can do more of the Level 4, 5, and 9 procedures
- Educational outreach increases
- Patients are satisfied with DHAT's services

Methodology



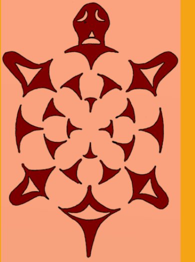
- Comparison of baseline year to treatment years (addition of DHATs)
  - Access – number of patients seen, less wait time for appointments
  - Production - # and types of procedures by IHS Levels, RVU of production
  - Production costs (overall clinic provider expenditures related to production)
  - Changes in educational outreach
  - Patient Satisfaction Surveys – baseline sample/quarterly treatment samples
- Monitoring for DHAT quality and safety
  - Chart review by supervising dentist
  - Outside review of a sample of patient charts
- Qualitative Interviews-Focus Groups

NARA Clinic Demographics



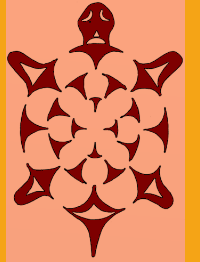
Report	Male	Female	Total
Baseline	606	854	1460
Qtr. 4 2017	357	468	825
Qtr. 1 2018	457	593	1050

Ethnicity NARA



Race	Qtr. 1 2018		Sample	
	#	%	#	%
American Indian/Alaskan Native	387	37%	63	82%
Hispanic	47	4%	1	1%
Native Hawaiian/ Other PI	6	1%	1	1%
White (not Hispanic or Latino)	155	15%	10	13%
Black/African American	43	4%	2	3%
Asian	11	1%	0	0%
Unspecified	401	38%	0	0%
Total	1050	100%	77	100%

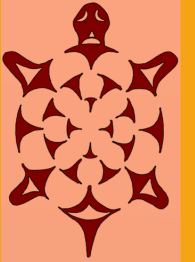
SES Proxy - NARA



Primary Production Source	Primary Production Amount	% of Primary Production
Oregon Health Plan (Medicaid)	$653,171.44	66%
HRSA	249,919.96	25%
Insurance	82,435.96	8%
TOTAL	985,420.36	100%

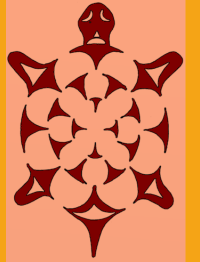
% of Federal Poverty Level	Primary Production Amount	% of HRSA Primary Production
HRSA 0-100 % FPL $0	$212,394.96	85%
HRSA 101-132% FPL $30	$14,743.00	6%
HRSA 133-149% FPL $40	$3,450.00	1%
HRSA 150-199% $50	$13,648.00	5%
HRSA Above 200% FPL Pt pays 100	$3,570.00	1%
HRSA Homeless	$2,114.00	1%
TOTAL	$249,919.96	100%

Production NARA



Report	Total procedures	Ahmed (dentist)		Wineland (dentist)		Other dentists		DHAT	
		#	%	#	%	#	%	#	%
Baseline	10,925	5,673	52%	3,484	32%	1,768	16%	0	0%
Qtr4 2017	4,439	2,253	51%	2,113	48%	0	0%	73	2%
Qtr1 2018	5,553	2,119	38%	2,322	42%	84	2%	1,028	19%

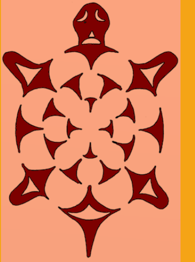
Patient Satisfaction – NARA Sample/Baseline



Respectful Treatment of Patients	Usually	Always
Explained things so it was easy to understand?	12%	88%
Listened carefully to you?	8%	92%
Treated you with respect?	4%	96%
Spent enough time with you?	5%	94%

Sense of Quality of Care	Good	Very Good	Not Sure
Preparing you for the dental procedure (numbing the area)	5%	88%	6%
Doing the dental procedure (filling, cleaning, etc.)	12%	83%	5%

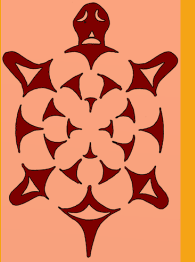
Patients Like Tribal or Native American Clinics



NARA - Ratings of Tribal Clinic in Comparison to Other Clinics	%
Not as good as the outside dental clinic	4%
The same as the outside dental clinic	31%
Better than the outside dental clinic	65%

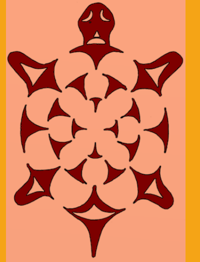
CTCLUSI Ratings of Tribal Clinic in Comparison to Other Clinics	%
Not as good as the outside dental clinic	5%
The same as the outside dental clinic	21%
Better than the outside dental clinic	74%

CTCLUSI Ethnicity



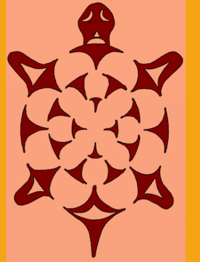
Ethnicity	Baseline		Qtr. 4 2017		Qtr.1 2018	
	Number	%	#	%	#	%
CTCLUSI Tribe	150	21%	111	22%	131	23%
Coquille Tribe	128	18%	78	15%	95	16%
Other Tribe	322	46%	260	51%	276	48%
Other	100	14%	62	12%	77	13%
Total	700	99%	511	100%	579	100%

SES Proxy - CTCLUI



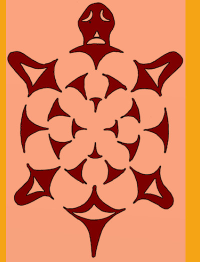
<table>
<tr><th>Type of Billing for Patient</th><th>Patient #**</th><th colspan="2">% for # Patients**</th><th>% Totals by Source of Payment</th></tr>
<tr><td>Medicaid</td><td>254</td><td>36%</td><td>36%</td><td>Medicaid</td></tr>
<tr><td>CTLUSI Tribal</td><td>51</td><td>7%</td><td rowspan="3">36%</td><td rowspan="3">Indian Health Service contract purchase care</td></tr>
<tr><td>Coquille Tribal</td><td>45</td><td>6%</td></tr>
<tr><td>Other Tribal Member</td><td>155</td><td>22%</td></tr>
<tr><td>CTLUSI Spouse</td><td>15</td><td>2%</td><td rowspan="2">4%</td><td rowspan="2">Covered by CTCLUSI or CIT tribal funds</td></tr>
<tr><td>Coquille Spouse</td><td>15</td><td>2%</td></tr>
<tr><td>Private Insurance</td><td>157</td><td>22%</td><td>22%</td><td>Insurance</td></tr>
<tr><td>Uninsured</td><td>8</td><td>1%</td><td>1%</td><td>Uninsured</td></tr>
</table>

Production - CTCLUSI



Report	Total Procedures	Rodgers (Dentist)		Macy (Dentist)		DHAT	
		#	%	#	%	#	%
Baseline	4667	4365	94%	302	6%	0	0%
Qtr. 4 2017	1803	1607	89%	27	2%	169	9%
Qtr. 1 2018	3685	2734	74%	0	0%	951	26%

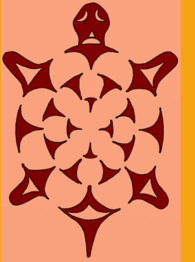
Patient Satisfaction -- CTCLUSI



Respectful Treatment of Patients	Some-times	Usually	Always
Explained things in a way that was easy to understand?	4%	22%	74%
Listened carefully to you?	3%	22%	75%
Treated you with respect?	1%/	22%	77%
Spent enough time with you?	4%	19%	77%

Quality of the clinic provider's care	Fair	Good	Very Good	Don't Know
Preparing you for the dental procedure (numbing the area)	1%	22%	71%	6%
Doing the dental procedure (filling, cleaning, etc.)	2%	19%	74%	5%

Monitoring Plan



- The Evaluation Plan has evolved to also include a detailed enhanced monitoring section, which includes the following appendices:
- Appendix B: Expanded Monitoring Plan
- Appendix C: Guide to Radiography and Intra Oral Images for Irreversible Procedures Performed by Dental Therapists
- Appendix D: Preceptorship Patient Encounter Form
- Appendix E: Dental Therapist CDT Billing Codes
- Appendix F: Dental Therapist Chart Review Form
- Dr. Lenaker oversees the web-based data collection from appendices D and F and that data is turned in every quarter in the Quarterly Reports to OHA.

DENTAL THERAPIST PRECEPTORSHIP: ALASKA AND OREGON

Dane Lenaker, DMD, MPH 6/18/2018

Table Of Contents

- History/Background
- Purpose
- AK / OR Comparisons
- Procedural Considerations

Graduation into Preceptorship

- Graduation Requirements
  - Passed didactic training
  - Passed clinical competency
  - Deemed ready to practice and begin preceptorship

Post Graduation Preceptorship

- Minimum Requirements
  - Competence AND
  - 3 months / 400 hours direct
- Often requires more time
  - Copious one on one time with dentists

Purpose

- Preceptorship is required a mentoring period
  - Verify competency of scope
  - Ensure familiarization with:
    - Organizational practice
    - Documentation styles
  - Gain familiarity with dental therapists strengths and weakness
    - Needing support is a normal part of the process

Dentist Supervision during Preceptorship

AK

- Training:
  - Completed within clinic or at ANTHC's training program

OR

- Training:
  - ANTHC's training program

ANTHC's DT Supervisor Training

- Extensive training on:
  - DHAT Training Overview
  - Preceptorship How-To
  - Certification Process
  - Leadership Trainings
- Foundational knowledge for how to work with DT's

Dentist Supervision during Preceptorship

AK

- Training:
  - Completed within clinic or at ANTHC's training program
  - Licensed-based calibration

OR

- Training:
  - ANTHC's training program
  - Appendices D as references for calibration

Preceptorship Documentation

AK

Dental Health Aide Therapist
Observation Log

DHAT NAME: ______________________________

ASSIGNED SITE: ______________________________

SITE(S) WHERE SUPERVISED FOR RECERTIFICATION:
____

SUPERVISOR(S) FOR RECERTIFICATION (NAME/ TITLE/ SIGNATURE):
____
____

Purpose:
The following is a list of procedures that the DHAT has been certified to perform and those procedures included in his/ her Scope of Practice. There is also an observation record to document a minimum of 80 hours of direct clinical observation of the DHAT performing these procedures. A certified DHAT should be able to perform these procedures

OR – Appendix D

Dental Therapist Evaluation Form

This form is designed to help support the evaluation of dental therapists with the NPAIHB. Please only fill out the relevant sections of this form.

Each section has a scoring criteria of "Acceptable" and "Unacceptable." Within each section, a short description of what that means is included.

* Required

Email address *
Your email

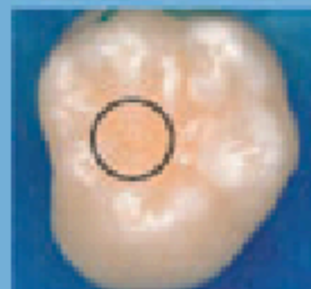
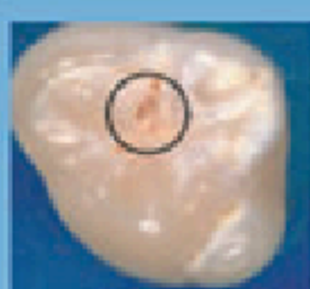
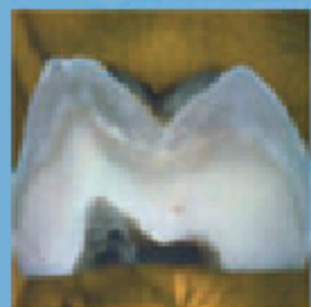
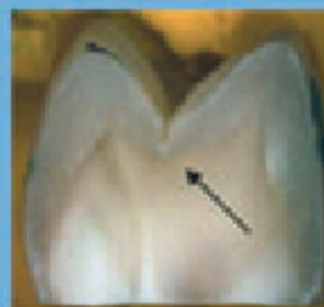
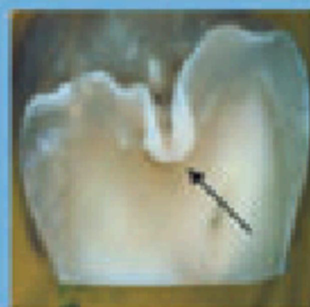
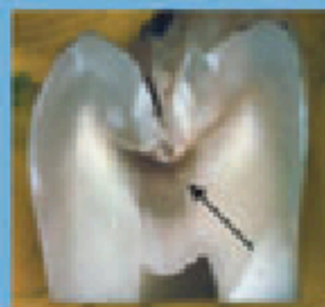
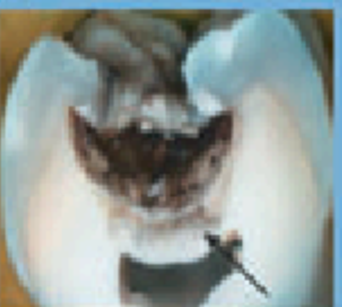
Dental Therapist Name *
Choose

Evaluating Provider's Name *
Choose

Organization *
Choose

Date of Service *
Date
mm/dd/yyyy

Unique ID *
Defined by NPAIHB - Ideally should be to pair an ID that can be crosswalked into Dentrix
Your answer

ICDAS score				
0	1	2	3–4	5–6
				
				

ICDAS codes, based on the histological extent of lesions, stage the caries continuum

Images provided courtesy of Dr Andrea Ferreira Zandona, University of Indiana

www.icdas.or

DT Preceptorship Evaluation

AK

- Each procedure
  - Dental Licensed-based assessment
- Generalized
  - Acceptable
  - Improvable
  - Unacceptable

OR

- Each procedure
  - Appendix F
- Highly Specific
  - Acceptable
  - Unacceptable

Examples of Critical Procedures

- Bitewings
- Periapical (anterior)
- Periapical (posterior)
- Photo (intra oral)
- Photo (extra oral)
- Caries Diagnosis
- Treatment Planning
- Fluoride Varnish
- Oral Hygiene Instruction
- Sealants
- Prophylaxis (tooth brush)
- Prophylaxis (scaling and polishing coronal surfaces)

Examples of Critical Procedures

- ART
- Protective Restoration
- Amalgam: Class I
- Amalgam: Class II
- Amalgam: Class V
- Amalgam: Complex (cuspal coverage)
- Composite: Class I
- Composite: Class II
- Composite: Class III
- Composite: Class IV
- Composite: Class V
- Stainless Steel Crown

Examples of Critical Procedures

- Pulpotomy (Primary)
- Pulpotomy (Permanent)
- Extraction (Primary)
- Extraction (Permanent)
- Local Anesthesia
- Charting
- Coding
- Notes

Oral Photos

AK

- During Preceptorship
  - Used as part of training
  - Checklist item
- After preceptorship
  - As requested by dentist

OR

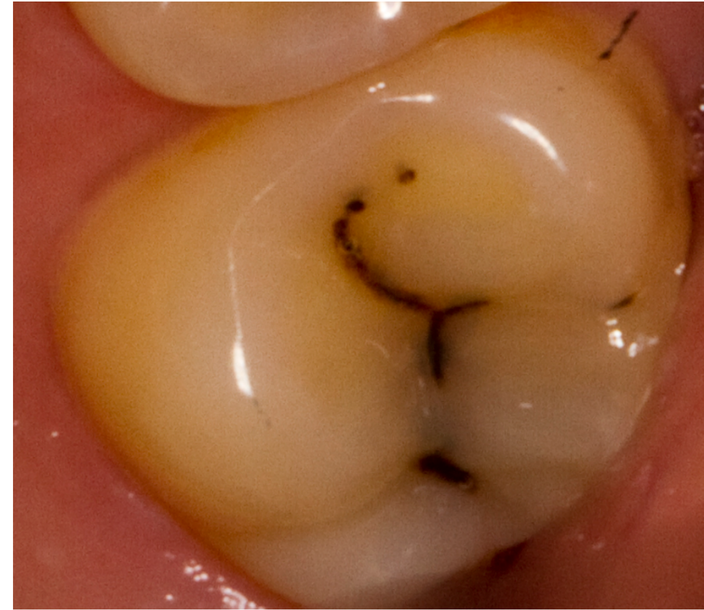
- During Preceptorship
  - Used as part of training
  - Checklist item
- After preceptorship
  - All irreversible procedures

I/O Photos

Notes:

- Helpful tools:
  - Electronic Dental Records
  - Digital Radiographs
  - Digital Camera and/or Intraoral camera

- Challenges:
  - Cost
  - Time
  - Technical requirements
  - Training
  - Patient Compliance



Primary Extractions

AK

- Subjective findings that coincide with an assessment that supports extraction
- Consultation with dentist not required

OR

- Has some degree of mobility
- Presence of purulence (suppuration)
- Odontalgia
- Not ankylosed
- Images, notes, and radiographs demonstrating:
- Must not be:
  - Impacted (erupted only)
  - fractured below the gumline
  - not decayed to the gumline
  - does not require sectioning for removal
- Patient must lack:
  - associated sepsis
  - facial swelling
  - trismus or dysphagia.
  - absence of dilacerations of the root(s)

Primary Extractions

AK

- All Supervision Levels

OR

- No proximity to vital structures including
  - maxillary sinus
  - inferior alveolar nerve
  - adequate clinical crown
  - no tori or other need for alveoplasty
- Documentation
  - must include any hemostasis required or other interventions.
  - post-operative instructions provided both verbally and in writing.
- Only under direct and indirect supervision

Permanent Extractions

AK

- Permanent Teeth
  - Subjective findings that coincide with an assessment that supports extraction
  - Medical Emergency
    - Pain

OR

- Notes:
  - percentage of bone loss
  - degree of mobility
- Diagnostic info:
  - probing depths
  - bleeding on probing
  - clinical attachment levels
  - presence and severity of gingival recession
  - presence of purulence (suppuration)
  - other supporting diagnostic criteria
    - including degree of odontalgia.
- Chart notes, including radiographic images and intra-oral images,
  - tooth is erupted (not impacted)
  - not fractured below the gumline,
  - Not decayed to the gumline
  - does not require sectioning for removal
  - illustrate the absence of associated:
    - sepsis
    - facial swelling
    - Trismus
    - dysphagia. Chart

Permanent Extractions

AK

- Permanent Teeth
  - Subjective findings that coincide with an assessment that supports extraction
  - Medical Emergency
    - Pain
  - All supervision levels

OR

- absence of dilacerations of the root(s)
- no proximity to vital structures including maxillary sinus and inferior alveolar nerve,
- adequate clinical crown
- No tori or other need for alveoplasty.
- Documentation
  - include any hemostasis required or other interventions.
  - post-operative instructions provided both verbally and in writing.
- Direct or Indirect Supervision

CHAP: Extractions and Supervision

- Sec. 2.30.610. Dental Health Aide Therapist Supervision and Competencies.
- (a) Dental Supervision. Dental health aide therapist services may be performed under this section by a dental health aide therapist under the **general supervision** of a dentist provided the dental health aide therapist has met the requirements of this section. Pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of **adult teeth** can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is *a medical emergency* that cannot be resolved with palliative treatment.
- Key Takeaways: General supervision and permanent teeth. Preceptorships are under direct supervision.

Difficult Procedures

- Common areas: patient management, extractions, SSC's, multi-cuspal restorations, etc
- Preceptorship is a time to challenge DT within scope
  - Similar (but more strict) with how one would supervise a new dentist
  - Improve existing skillset
  - Learn comfort levels
  - Dentist available if complication arises

No mal practice or tort claims

- Professional
- Competent
- Safe
- Outcomes Study
  - Dental therapists linked to improved dental outcomes for Alaska Native communities in the Yukon-Kuskokwim Delta

Questions?

Contact Info

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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May 11, 2018

Dr. Bruce Austin, State Dental Director
Oregon Health Authority
800 NE Oregon St.
Portland, OR 97232

Dear Dr. ~~Austin~~ Bruce,

We appreciate the opportunity to provide a final detailed response to the NARA site visit findings sent to us on April 9, 2018. This response has been drafted and reviewed by our project staff, and our consulting and site dentists. OHA findings are numbered and in bold.

1. Failure to Follow OHA Directives: On November 27, 2018, OHA issued a notice to NPAIHB requiring the project to cease providing planned extractions by dental health aide therapist (DHAT) trainees since it is outside of the scope of practice requirements as outlined in the approved application. NPAIHB failed to inform the project sites of the directives issued by OHA. DHAT trainees at the pilot project sites continued to perform planned extractions outside of the requirements that they be a medical emergency. Medical emergencies are defined under ORS 682.025 and OAR 141-120-0000.

The November 27th 2017 letter to NPAIHB included one directive:

Until the request for modification has been reviewed and either approved or denied, trainees operating in the pilot project may continue to operate. However, trainees are required to continue to operate under direct supervision as outlined in the approved application. Trainees may continue to provide extractions as outlined in the CHAP Standards and Procedures, Section 2.30.610, "extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment."

Pilot projects that continue to operate without approved modifications are in violation of Oregon Administrative Rules (OARs) and are subject to suspension or termination as outlined in OAR 333-010- 0470.

Pilot Project #100 stands by our assertion that DHAT and supervising dentist were operating under the above directive. The trainees were both still in preceptorship, which requires direct supervision, and performing extractions

based on the interpretation of medical emergency as interpreted by dentists in Alaska.

To this point, after confirming our understanding by again consulting with our consulting dentists, Dr. Dane Lenaker, and Director of the Alaska Dental Therapy Education Program, Dr. Mary Williard we wrote in a letter dated November 30, 2017 from NPAIHB to OHA:

There is no definition of medical emergency in the CHAP standards or the IHCIA language from which the standards were revised. Tribal organizations in Alaska have interpreted medical emergencies in a dental context of alleviating pain that cannot be resolved with palliative treatment. The decision to extract rests with the supervising dentist during the required consultation under all supervision levels.

After sending the November 30, 2017 letter to OHA, it was never communicated to the project that our interpretation was incorrect. OHA has never directed Pilot Project #100 to use the definition of medical emergency cited from the OARs verbally, or in writing. The above referenced OAR definition of medical emergency was a handout in the packet distributed to Advisory Committee members at the February 5, 2018 meeting, without any reference or discussion. It was never verbally or in writing communicated to project staff that there was an expectation that DHATs and supervising dentists would utilize this definition.

While OHA has already determined what it will accept as a modification to this extraction language moving forward, we respectfully request that this finding be removed from the record as there was no formal direction from OHA to operate differently than our stated intent on November 30th.

2. **Nitrous Oxide: DHAT trainees at the pilot sites provided services to patients who were under the use of nitrous oxide. Nitrous oxide was administered by the supervising dentist under direct supervision.**

   In an addendum to their approved application, NPAIHB states "The DHATs are not trained to use it; they will not be using Nitrous Oxide." At subsequent Advisory Committee meetings, the NPAIHB was questioned as to the methodology and logic of excluding DHAT trainees from receiving training on nitrous oxide when it is used at each pilot site.

   On October 31, 2017, the NPAIHB stated that "Nitrous is used at both NARA and CTCLUSI, but for the purposes of this pilot, we have decided at this point not to modify our application to include additional training in Oregon on Nitrous Oxide for DHATs. DHATs are able to provide treatment to a patient that is placed under Nitrous Oxide or other analgesics."

   On November 21, 2017, OHA informed the NPAIHB in writing of the following requirements:

I. **If DHAT trainees are providing treatment to patients under "nitrous oxide or other analgesics," then OHA requires that the trainees participating in the approved pilot project follow the Oregon Board of Dentistry administrative rules for Anesthesia OARs 818-026-0000 through 818-026-0120.**

II. **The project must provide clarification on the intention of using nitrous oxide by DHATs in the pilot project, as well as the training received and competency if operating as an Anesthesia Monitor, etc.**

III. **If it is the intention of the project trainees to utilize nitrous oxide or work on patients under nitrous oxide, then the project must apply for a modification to their application.**

A copy of the administrative rules for nitrous oxide OARs 818-026-0000 through 818-026-0130 was supplied to the NPAIHB.

On November 30, 2017, OHA received a memo from NPAIHB stating: "After further review of the Oregon Dental Practices Act, we agree that our DHATs are not, and will not be authorized to administer Nitrous Oxide, or work on patients that have received Nitrous Oxide from someone who has a valid Nitrous Oxide permit."

NPAIHB failed to inform the project sites of the directives issued by OHA. The DHAT trainees at both pilot sites provided services to patients who were under the use of nitrous oxide.

Pilot Project #100 acknowledges this directive was not communicated as clearly as it should have been, and agrees to follow the stipulated agreement accordingly. It is our intent to comply with the "Required Next Steps" to develop written standard operating procedures (SOPs) and reference resources, and to conduct training sessions. We have heard from our clinics that ultimately, having the ability for DHATs to work on patients that have received Nitrous Oxide would be beneficial to patient care and the efficiency of the clinic. We will continue to explore with OHA a modification to allow for DHATs to receive the appropriate training and authorization.

3. **Practicing Outside the Scope of Approved Practice: Review of the chart records indicate that on three separate occasions the trainee completed extractions or attempted to complete extractions, which are outside of the trainees approved scope of practice as outlined in the Community Health Aide Programs Board (CHAP) Standards and approved application:**

   As stated in the approved application under CHAP Standard 2.30.610, in addition to the requirement that extractions must be completed by DHAT trainees in the event of a medical emergency, DHAT trainees are authorized

to complete uncomplicated extractions with prior evaluation of the x-ray and consultation when appropriate for proximity to the mandibular canal; proximity to the maxillary sinus, root fractures or dilacerations; multiple roots; a well-defined periodontal ligament space; and enough clinical crown to luxate the tooth.

Project trainees are only authorized to complete simple uncomplicated extractions. In two of these instances, the procedure became surgical in nature in order to complete the procedure.

A. **In the first instance, the trainee attempted to extract tooth #20 with no clinical crown above the gingival level. Radiographs demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was unable to extract the tooth and required intervention by the supervising dentist. The dentist was required to cut a flap in order to extract the tooth.**

B. **In the second instance, the trainee extracted teeth #15 and #16. Chart notes state that after the teeth were extracted by the DHAT trainee, buccal bone was attached to the extracted teeth. The supervising dentist was required to take over the procedure and used a bone file to reshape the bone in the extraction site and suture the area.**

C. **In the third instance, the trainee extracted teeth #18 and #19. Tooth #18 had no clinical crown. The two remaining roots of #18 were embedded in the soft tissue. Both radiographs and intra-oral images demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was successfully able to extract the teeth.**

OHA is concerned that the DHAT trainee was authorized to complete procedures that fell outside of their scope of practice according to the approved project application. DHAT trainees do not have the scope of practice to cut soft tissue or resolve extractions that become surgical in nature. The NPAIHB has stated on several occasions that the DHAT trainees are taught the limitations of their scope of practice and are aware of those limitations. Of particular concern is that the DHAT trainee at the NARA site has been practicing for over 8 years.

There is considerable concern that the project's intention is to have the DHAT trainee complete extraction procedures under general supervision. Had the DHAT trainee been authorized to complete these procedures under general supervision, with no dentist on-site, the DHAT trainee would have lacked the necessary skills to complete the procedure. This would have resulted in undo pain for the patient and would have necessitated a referral to a dentist to complete the procedure.

From Dr. Azma Ahmed, supervising dentist:

"A. This procedure was performed under direct supervision. #20 has PARL all around the tooth. When the radiograph shows radiolucency all around the tooth, this usually translates to mobility. In cases of mobility, sometimes forceps are not really necessary for extractions. The assumption was that the DHAT trainee could use a periotome to detach PDL and elevate the tooth and get the tooth mobile enough that the only reason to use a forcep would be to hold the tooth and remove it. The only thing I did was to detach the interdental papilla on the mesial in order to engage the forcep during this extraction. This is a step that is sometimes necessary, in cases of extractions. The DHAT trainee recognized that in order to engage the forcep, the papilla may need to be detached and called his supervising dentist in to complete the procedure. He did exactly what was expected of him – recognize the limitations of his scope of practice and consult with supervising dentist in case there are any questions. This said, this tooth was recommended to be extracted by the DHAT because the trainee was under direct supervision. If it were under general supervision, this case would not be recommended for completion by the DHAT.

B. #15, #16 Maxillary buccal plate is very thin and buccal plate fracture is a potential complication of extraction – especially for a Maxillary 2nd molar. The use of a bone file and sutures are necessary to manage this complication. This procedure was also performed under direct supervision and is not something that would be completed under general supervision. The DHAT trainee did not use the bone file or place sutures. The DHAT trainee is experienced and as the supervising dentist I am comfortable with him practicing at the top of his scope.

C. #18, 19 There was less than 5% bone support remaining on #18 and #19. The teeth were removed as a simple extraction using elevators. The DHAT scope of practice is simple uncomplicated extractions and these teeth fall into that category."

The trainee was working within his scope of performing an "uncomplicated extraction" in all three of these cases. The opportunity for DHATs to carry out procedures at the more difficult top of their scope and determine comfort levels with such procedures--under direct supervision during the preceptorship--is a responsible way to understand the individual DHAT's skills and comfort levels within their scope.

In determining what would be marked acceptable and unacceptable during the preceptorship, the project and clinics intentionally did not include "intervention by dentist" in the criteria for unacceptable. This was intentional to signal to DHAT trainees that asking for help and referring on patients to the supervising dentist would not be penalized and is an expectation (not an exception) when a DHAT believes that he/she cannot or should not complete a procedure. We did not want to create an environment where DHATs believed they would be penalized for following protocol. It is an established protocol that if a DHAT believes that they cannot or should not complete a procedure that the patient is referred to their supervising dentist or another appropriate provider. This is an important protocol and is an expectation that every

supervising dentist should have from their DHAT.

In the case of determining whether or not to deem a procedure "acceptable" or "unacceptable" the supervising dentist takes into account clinical skill, patient interaction, adherence to protocol, clinical judgement, and other factors related to the delivery of care. In the case of extraction "A", the DHAT trainee was marked acceptable for following protocol and referring the patient to the supervising dentist to complete the extraction. In the case of extraction "B" the DHAT trainee was marked acceptable because he followed protocol and referred the patient to his supervising dentist. Managing complications, even if that means referring them to the appropriate provider, is an important skill and a critical part of a provider's clinical judgement/reasoning.

The language cited by OHA "***DHAT trainees are authorized to complete uncomplicated extractions with prior evaluation of the x-ray and consultation when appropriate for proximity to the mandibular canal; proximity to the maxillary sinus, root fractures or dilacerations; multiple roots; a well-defined periodontal ligament space; and enough clinical crown to luxate the tooth*"** is not part of the CHAP standards. This language comes from the Practice Plan Template (not in use at the time because it is signed after the preceptorship is completed) which gives instructions and considerations for extractions under general supervision after the DHAT completes the preceptorship.

For the above reasons, we are respectfully requesting that OHA remove this finding from their final NARA site visit report.

The new Practice Plan Template under review, per directions from OHA, includes the new clinical parameters in which all extractions must be done under indirect supervision with mobility and bone loss requirements.

In our Quarter One report submitted to OHA on May 1, we included a gap analysis provided by the Alaska Dental Therapy Education Program to identify the competencies required for graduation in 2017 that were not in place when Ben Steward graduated. Ben will receive this additional training in early June, including a course on suturing.

The project remains committed to patient safety, quality care, and clinic efficiency. We look forward to ongoing dialogue about extractions in the project and how to best meet the needs of our patients. Our project intends to comply with the stipulated order and to fulfill the required Standard Operating Procedures, reference resources and training.

4. Informed Consent: The project failed to obtain written informed consent for services by the trainee on the date of service, as required in OAR 333-010-0440 and OAR 123-456-7890, on multiple occasions in charts provided for review

– including treatment of 3 minors. On four occasions, the signed consent to be treated by a trainee was obtained after the initial date of service. On two occasions, the printed patient name is not listed on the signed informed consent form. On one occasion, informed consent to be treated by the trainee was absent entirely. Overall, only 74% of the 23 charts reviewed in the randomized sample had a signed form consenting to treatment by the DHAT trainee on the initial date of service.

Additionally, an approved oral surgery consent form is required for all extractions. Of the 9 charts reviewed for which an oral surgery consent form is required, only 1 chart had a signed oral surgery consent form that matches the form approved for the pilot project. For the remaining charts, 7 charts included a different oral surgery consent form. Written consent for oral surgery is missing entirely for one chart.

The NARA clinic staff responsible for obtaining informed consents have immediately changed their protocols making the DHAT informed consent electronic and part of the patient chart. During the morning staff meeting, schedules are checked to indicate patients that have not yet been seen by the DHAT. Regular self-audits have been implemented moving forward. Our project intends to comply with the stipulated order and to fulfill the required Standard Operating Procedures, reference resources and training to make sure the new protocols are adequate to ensure success.

After reviewing the charts in questions, NARA staff indicates the surgical informed consent forms contain the same language as the form submitted to OHA. When the approved form was inputted into Dentrix, not all of the formatting translated into Dentrix. When this form is printed the language remains the same but the formatting is different. The project requests that the printed electronic version (from Dentrix) be approved alongside the original, approved printed version so that the site can be in compliance with the requirements of the project.

5. Non-Adherence to Approved Evaluation & Monitoring Plan: Based on review of the 23 submitted charts, the project is not in compliance with Appendix C intra-oral image and radiographic collection requirements of the approved Evaluation and Monitoring Plan.

In the 23 charts submitted, there were 42 unique procedures identified that required a pre- and post-operative intraoral image. Of these, 12 procedures (29%) were missing a pre-operative and/or post-operative intraoral image. Additionally, restoration procedures require an intraoral image of the tooth prep, which was missing in 5 of the 31 identified procedures requiring a prep image. Adequate patient safety and procedure quality cannot be determined without proper image documentation.

Pilot Project #100's Evaluation and Monitoring Plan, Approved by OHA on January 27, 2017 states:

2. Evaluating dentist monitoring after preceptorship.

***After the DHAT has completed the preceptorship** (emphasis added), the monitoring for safety and quality will be achieved by evaluation of the DHATs work both by the supervising dentist and by a dentist not affiliated with the clinic in which the DHAT is working. The evaluating dentist must be licensed, will be selected by mutual agreement between NPAIHB and the pilot site, and will not have financial conflict of interest in the project.*

*Every week, the supervising dentist will review all charts of irreversible procedures performed by the DHAT. Every quarter, 10 charts drawn from a random sample containing irreversible procedures will be reviewed by the evaluating dentist. Protocols for radiography and intraoral photography per procedure are in **Appendix C and will be used to ensure the evaluating dentist can adequately assess the quality of the DHAT's work** (emphasis added).*

This language was crafted in response to OHA's concerns that ***after preceptorship***, it would be a challenge for the supervising dentist and external reviewing dentist to see what the DHAT was presented with and adequately review procedures. Pilot Project #100 had lengthy conversations with OHA on how best to modify the plan to accommodate these concerns, and created Appendix C, weekly review of irreversible procedures, and review by an external dentist, as a result of those conversations. It was the understanding of the project and clinical staff that Appendix C was to be used by the project after preceptorship per our approved evaluation and monitoring plan.

To ensure familiarity with requirements, protocol, and equipment, the clinics started training the DHATs during their preceptorship on the images required in our Evaluation and Monitoring plan. As required by our approved Evaluation and Monitoring plan, the project and clinical staff wanted to be certain that after the DHATs completed their preceptorship they would be able to consistently meet those requirements.

There is clearly a misunderstanding between the OHA and the Project about how to interpret the Evaluation and Monitoring plan. We respectfully request in person or phone conversations to go through the evaluation and monitoring plan to ensure that the project understands how OHA has interpreted the evaluation and monitoring plan. The project is also requesting that after every modification is approved that OHA schedule a call with project staff to ensure common understanding of any modifications and that modifications not go into effect until after that call and common understanding has been established.

We respectfully request the removal of this finding from the record as it is in direct conflict with the requirements of our approved Evaluation and Monitoring Plan as it is approved today. The section in question is Appendix B which has two sections:

- Section 1. Supervising dentist monitoring during preceptorship which references Appendix D, a web-based tracking form and Appendix E, codes associated with procedures.

- Section 2. Evaluating dentist monitoring after preceptorship which references Appendix C, the radiography and intraoral photography requirements for per procedure and Appendix F, a chart review form to be used by both dentists.

The project and clinical staff interpreted this to mean that during the preceptorship, DHATs and Supervising dentist requirements would be found in Section 1 and after the preceptorship, DHAT and supervising dentist requirements would be found in Section 2.

If the project's interpretation of Appendix B of the evaluation and monitoring plan is incorrect, we respectfully request OHA work with the Project to amend the evaluation and monitoring plan to avoid any further confusion.

6. Failure to Submit Required Information to OHA as Required: As part of the site visit, the project was required to submit a randomized sample of charts to OHA by February 27, 2018 based upon quarterly data submitted in the Detailed Data Report. Upon review, it was determined that a significant portion of these charts were incomplete and were missing significant components required for review and assessment of quality. These include pre-operative intra-oral images, prep intra-oral images, post-operative intra-oral images, pre-operative radiographs and informed consent forms.

Reviewers were unable to adequately assess several of these charts as required for evaluation of patient safety. Of the 24 charts requested, 63% were missing one or more element. OHA further requested the missing components of the charts and received most of the required materials on March 16, 2018. Project managers indicated on that date that one chart number had been included in the Detailed Data Report in error, and was not a patient seen by the trainee.

NARA clinic staff did experience technical difficulties transmitting the charts, and as noted by OHA, submitted missing elements by requested date. Project #100 acknowledges that we can do better in this area and worked closely with the sites to train DHAT coordinators and worked closely with onsite IT staff to get the information necessary out of Dentrix to better meet the needs of OHA. Regarding the missing pre-operative, prep, and post-operative intra-oral images and pre-operative radiographs, the project was not collecting these per our interpretation of Appendix B, Section 1 and Section 2 of the evaluation and monitoring plan. We anticipate that this will not be an issue going forward

7. Detailed Data: The project is required to submit a full and complete detailed data report (DDR) to OHA quarterly. Upon review of the DDR and comparison of the chart records, numerous procedures were omitted on the detailed data report. Instructions for submission of the DDR indicate that every service provided by the trainee must be included as a separate entry. Stratified random samples are selected from the information contained in the DDR, so accuracy of the DDR is critical to the required evaluation by OHA.

Based upon the submitted DDR, there were an expected 41 unique procedures

(defined by ADA CDT codes) completed by the trainee on 23 unique patients. After review, there were 102 unique procedures identified as being completed by the trainee. Of the 23 charts reviewed, only 35% were accurately represented in the DDR. The procedures omitted in the DDR include one completed extraction, as well as many preventive and restorative services. This is an indication of severe data validity issues in the detailed data reports as submitted. Without a complete data set in the DDR, conclusions cannot be drawn as to the representative nature of the charts submitted. It is unknown how many other procedures have been completed by the trainee that were not included on the DDR for charts not selected in the randomized sample.

Clinical and project staff are committed to data integrity and transparency. Project staff have benefitted immensely from the assistance in interpreting the detailed data report request since February 28th, 2018. The addition of the data dictionary and the in person meeting with staff and our evaluator gave us the tools that we needed in order to interpret this request and assure adherence for future reports from the clinical sites.

The project repeatedly requested assistance with interpreting this request and unfortunately that did not happen until after the deadline for submission.

- October 2nd project staff requested information in order to comply with reporting requirements and were told that OHA would get back to project staff.
- October 26th project staff received a template for data requested and the same day sent back requests for clarification. OHA responded that day that they would get back to project staff.
- November 7, 2017 project staff received an email from Dr. Austin stating: "Going forward, I'll be sending most future communications by email. Please direct future correspondence directly to me and I will update OHA staff accordingly."
- OHA responded that they would send clarification by November 21st and a revised version of the progress report template on Nov 22nd
- November 27th project staff received an email that included newly revised coversheet, quarterly data specification, quarterly data summary template, and quarterly data detailed report template.
- November 30, 2017 project 100 notified OHA in a memo about the need for further conversation with staff about the detailed data report.
- December 8th Project staff again sent a memo to OHA requesting further conversation about the detailed data report.
- January 27th, Pilot project 100 received approval of our evaluation and monitoring plan which does not include the new reporting requirements from OHA even though there are discrepancies in both the data and the format OHA requested in the Quarterly Report Data Specifications document sent November 27, 2017.
- Project staff repeatedly requested consultation on the detailed data report and were told that OHA would not meet with project staff until after the New Year.
- Project staff, OHA, and the project evaluator were able to meet with OHA on February 28th, after the deadline for submission.

Clinical and project staff remain committed to data integrity, transparency, and ensuring that OHA has the data necessary to monitor the project. Project staff endeavors to be the best resource possible for our clinical staff and in order to meet that goal, project staff needs to have timely and open communication with OHA staff.

Project staff respectfully requests that there be regular, scheduled communication between OHA staff and project staff so that the project can best meet the requirements of OHA. We are requesting a regularly scheduled phone call with relevant staff to allow a forum for project and clinical staff to get clarification on requests and requirements from OHA. This will help us better meet the needs of OHA and demonstrate our commitment to data integrity and transparency.

8. Failure to Document: The pilot site has failed to maintain accurate patient records in accordance with OAR 818-012-0070. Examples include incorrectly recording treatment rendered, incorrectly coding for one procedure when a different procedure was performed, and not recording patient weight when administering analgesics to minors.

Additionally, in one instance, the trainee completed an extraction that was coded as D7210, which falls outside the scope of DHAT practice. D7210 is defined as surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Project managers indicated that this was coded in error, which indicates a failure to accurately document patient treatment.

In order for clinical and project staff to investigate findings from this report and take the appropriate steps necessary to rectify any deficiencies, clinical site staff are requesting that OHA send NARA the chart numbers on the charts in question so that NARA staff can investigate this finding.

9. Advisory Committee: The project failed to meet with their own advisory committee in the two years since approval of the dental pilot project. The approved application includes details of the project assembling an Advisory Committee of their own and meeting regularly. The project has not met once in two years since the approval of the project in February 2016.

The Advisory committee for project #100 has been an invaluable and essential partner throughout the life of the project. Their contributions to the approved application, existing policies and procedures, and evaluation and monitoring plan, as well as the support they have provided to both clinical and project staff is immeasurable and has been vital to the creation of the project foundation.

Our approved application states:

- *Upon approval of application, NPAIHB will establish an Advisory Committee to:*

- *Monitor and evaluate the safety, effectiveness, and overall success of project.*
- *Make recommendations and suggest improvements based on yearly evaluation*
- *Evaluate completeness of data collected on a yearly basis*
- *Understand the goals and objectives of the project and help their respective communities understand those goals and objectives*
- *Offer expertise to staff when troubleshooting any unanticipated challenges*

OHA is asserting that the project has not met with its advisory committee over the last two years and we respectfully disagree. Our advisory committee is committed to the project and the relationships we have with the committee are extremely important to the project. The project has regularly consult with the experts available as part of our advisory committee as necessary to troubleshoot and in order to inform the foundation of the project. As busy professionals, we have worked hard to be respectful of their time. Until this year, the project did not have data to evaluate and have scheduled an annual meeting to go through the data and receive recommendations about improvements.

As a reference, we have made a short list of some of the ways that our advisory committee has worked closely with us over the past two years:

Christopher G. Halliday, D.D.S., M.P.H.
RADM (ret.), USPHS
Deputy Director, Division Of Oral Health, Indian Health Service HQ
Dr. Halliday is the newest member of the committee, prior to his addition to the advisory committee, Dr. Cheryl Sixkiller occupied this spot on the advisory committee and provided guidance and advice on the potential for working with IHS direct service clinics, and participates in the Board's monthly Dental calls where we give updates on the pilot project.

Victoria Warren-Mears, PhD, RDN, FAND
Director, Northwest Tribal Epidemiology Center
Victoria directs our Epi-center at NPAIHB and has over the past two years consulted directly and has offered her staff for technical assistance on creating our evaluation plan and data collection.

Mary Williard, DDS
Director, Alaska Dental Therapy Education Program
Alaska Native Tribal Health Consortium
Dr. Williard has been involved in every aspect of this project. She directs the education program that is training our students, she has a full understanding of the CHAP Standards and Procedures, she has conducted detailed clinic reviews of our site clinics prior to DHATs starting at each clinic, reviewed and offered input on our Application and Evaluation Plan, hosted the ADTEP site visit by OHA, provided supervising dentist training to all of our supervising dentists, clinic leadership, hygienists, and DHAT coordinators. She has been available and immediately

responsive not only to our staff and clinic staff but also to OHA staff whenever request are made.

Kelle Little, RDN
Health and Human Services Administrator
Coquille Indian Tribe Community Health Center
Kelle is the main liaison between the Tribe and Pilot Project #100 and was involved in review and drafting of Application, and review of Evaluation Plan. She recruited and supports the two Coquille students in their training and utilization phase, communicates with Tribal members about the project and is the liaison between the project and Coquille Tribal council. She has also represented the project in public educational forums. She regularly reviews and offers feedback on how project decisions will impact the Coquille DHATs and patient population.

Vicki Faciane
Health and Human Services Administrator, Conf. Tribes of Coos, Lower Umpqua and Siuslaw Indians
Vicki is the main liaison between the Tribe and Pilot Project #100 and was involved in review and drafting of Application, and review of Evaluation Plan. She recruited and supports the two CTCLUSI students in their training and utilization phase, communicates with Tribal members about the project and is the liaison between the project and CTCLUSI Tribal Council. She has also represented the project in public educational forums. She supervises the Dental Director and oversees management of the dental clinic. She regularly reviews and offers feedback on how project decisions will impact the CTCLUSI clinic, staff and patient population.

Allyson Lacatsas
Director of Health Services, NARA
Allyson supervises the Dental Director at NARA, and oversees management of the dental clinic. She is the liaison between the project and the NARA Board. She regularly reviews and offers feedback on how project decisions will impact the NARA clinic, staff and patient population.

Chief Warren Brainard
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
Chief Brainard has been key to communicating the need for the pilot project within his own community which helped establish CTCLUSI as the first pilot site, and to others in public education forms and on the Oregon Legislative Council on Indian Affairs.

Rachael Hogan, DDS
Dental Director, Swinomish Indian Tribal Community
Washington State Dental Association Member
Arcora Foundation Board Member
Dr. Hogan was the first supervising dentist to a DHAT in the lower 48, and helped create the Swinomish Dental Provider Licensing Code. Her advice on implementing

the successes in Alaska to new authorizing codes and legislation has been instrumental in our work in Oregon. She reviewed the Evaluation Plan (and is using a version of it at the Swinomish clinic) and has consulted on the accelerated preceptorship process which she established at Swinomish. She regularly provides support and consultation not just to project staff but also to the supervising dentists in the project.

Frank Catalanotto, DMD
Professor, Department of Community Dentistry and Behavioral Science
University of Florida College of Dentistry
Dr. Catalanotto provided an early review and input to the Evaluation Plan and regularly checks in with project staff on the progress of the project.

The utilization phase of the project started July 2017, and we have scheduled an in person committee meeting August 21, 2018 to do the required yearly review of the project.

We are setting up quarterly meetings with the committee and working with the committee to create structure around the committee to facilitate formal interaction with the committee going forward. The Project respectfully requests that this finding be removed as it does not accurately reflect our utilization of our advisory committee nor the project staff's commitment and adherence to our approved application over the last two years.

10. Project Management: There is considerable concern that the NPAIHB is failing to adequately communicate clinical concerns with the project sites. Supervising dentists at each pilot site have indicated frustration with a lack of communication on issues which are highly relevant and time sensitive. Concerns remain that the NPAIHB does not have a clinical dental subject matter expertise in the project manager role. There remains ambiguity and inconsistencies regarding clinical questions and concerns raised by both OHA and the Advisory Committee around extractions, nitrous and suturing. Several statements received by OHA from the project have contradicted each other and have caused concern regarding patient safety and the provision of quality care.

NPAIHB has engaged five dentists directly on the day to day operation of this project. Dr. Azma Ahmed and Dr. Sarah Rodgers, the supervising dentist and dental director at each operating clinical site, Dr. Emily Wineland, supervising dentist at a clinical site, Dr. Mary Williard, the Director of the ADTEP, and Dr. Dane Lenaker, an experienced dentist with a long history of working with DHATs, expert level experience with Dentrix, experience utilizing data extracted from Dentrix for evaluation purposes, and vast clinical experience as a practicing dentist. Each of these dentists provide subject matter expertise to the project. As members of our advisory committee there are a number of other dentists advising the project staff on matters related to clinical dentistry and clinic operation. The project staff does not make clinical decisions. The project staff's primary role is administrative
All clinical and project decision are made by the project dentists on site and advised by both Dr. Williard and Dr. Lenaker as well as dentists from the advisory committee as

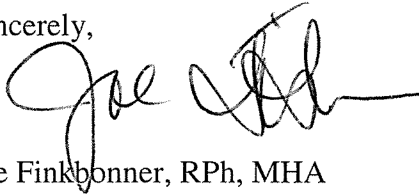
necessary. The structure of this team ensures that project dentists have the ability to structure their individual sites to best meet the needs of their patients, utilize their limited resources efficiently, and ensure the safety and quality of care.

The projects intent is to follow the stipulated agreement and we have contracted with Dr. Gita Yitta. The project has been and remains committed to patient safety and provision of quality care. We have complete confidence in our clinical staff in both ensuring patient safety and the provision of quality care.

NPAIHB agrees that communication between project staff and clinic staff needs to improve. To that end, after the February advisory committee meeting, Project staff has required that at least one site dentist be in attendance in person to each advisory committee and annual meeting. We have implemented monthly all hands calls between clinical staff, clinic leadership, NPAIHB staff, and DHAT coordinators. We have a new policy of scheduling a phone call to walk through each communication from OHA with clinical staff within one week of receiving each communication to allow clinical staff to ask questions and discuss each communication. Even though project staff often consults with clinical staff in response to letters received from OHA, NPAIHB will also be scheduling a phone call prior to submitting any formal response to OHA to walk through each response with clinic staff and leadership.

Thank you for your consideration of above comments, and the ongoing work you and your staff are doing to provide oversight to this project.

Sincerely,



Joe Finkbonner, RPh, MHA
Executive Director,
Northwest Portland Area Indian Health Board

CENTER FOR PREVENTION AND HEALTH PROMOTION
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Dental Pilot Project Advisory Committee
Dental Pilot Project #100
"Oregon Tribes Dental Health Aide Therapist Pilot Project"
SMALL GROUP DISCUSSIONS
June 18, 2018

Task #1

The Oregon Health Authority (OHA) is tasked with reviewing and evaluating the workforce model being tested in each approved dental pilot project and providing a closing report at the conclusion of the pilot project.

OHA is seeking input from the Advisory Committee on the topic areas that should be included in the final report.

- DPP #100 was approved to operate from 6/1/2016 - 5/31/2021

In your small group, please identify main topic areas that should be included, as well potential subjects to cover under each topic area.

Example of a main topic area: **Education Requirements**

Subjects to include:

a. **Accreditation requirements**
b. **Admission requirements**
c. **Competency examinations**
d. **…..**
e. **…..**

Task #2

A. Goals of future Advisory Committee meetings
B. Prioritize topic areas for discussion